

PAPERWORK CHECKLIST

EMPLOYEE NAME: _____

1. ☐ **Application:** Attachments: 1, 2, 3, 4 & 5 (If 5 is yes, must also have "Substance Form" below)
☐ **Resume** ☐ **N/A**
2. ☐ **Florida Drivers License Check** OR ☐ **Letter Sent** ☐ **N/A**
3. ☐ **Out of State Drivers License Check** OR ☐ **Letter Sent** ☐ **N/A**
4. ☐ **Alcohol & Control Substance Form** (Safty Sensstve previous 2 yrs) OR ☐ **Faxed** ☐ **N/A**
5. ☐ **Life Insurance Card** (No Temp or under 25 hpw) ☐ **N/A**
6. ☐ **Health Insurance Enrollment Form** ☐ **N/A**
7. ☐ **New Hire Reporting Form** (Unemployment)
8. ☐ **Emergency Contact Form**
9. ☐ **Physical Papers** (Employee Takes to Appt. – Attach copy of job description)
10. ☐ **Waivers:**
☐ **CDL** ☐ **N/A**
☐ **Background/Arrest Record - Authorization to check**
☐ **Temp or** ☐ **Grant** ☐ **N/A**
☐ **Trainee Waiver** ☐ **N/A**
11. ☐ **Retirement Questionnaire**
12. ☐ **Good Moral Character** (In Home Services Only) ☐ **N/A**
13. ☐ **W-4**
14. ☐ **I-9**
15. ☐ **Florida Drivers License copy** ☐ **N/A**
16. ☐ **Social Security Card copy** (no metal – must be signed) OR ☐ **copy of letter from Social Security office stating date applied for new card (inform new employee that they will not be able to start working without either one of these!!)**
17. ☐ **Job Description** (signed) – copy to employee ☐ **N/A**
18. ☐ **ID Form/Employee Tag** ☐ **N/A** ("NO" drive if no Fl DL and/or past 3 year DL check)
19. ☐ **Picture Taken** ☐ **N/A**
20. ☐ **Newsletter Form** (KW: Take Pic w/digital camera)
21. ☐ **PPM Receipt**
22. ☐ **Policy Receipts 1003** (Safety & Travel Procedures)
23. ☐ **EMS Addendum** ☐ **N/A**
24. ☐ **Drugfree Workplace Receipt (4703)**
25. ☐ **DOT Policy Receipt** ☐ **N/A**
26. ☐ **EEO Form**
27. ☐ **Public Records Request** (EX/NON)
28. ☐ **FRS Booklet (Regular or Special Risk) and Bulletin if available** ☐ **N/A**
29. ☐ **Savings Bond Info**
30. ☐ **Valic & Nationwide Info**
31. ☐ **Transcripts** (Sent directly from School to Personnel office) OR ☐ **Letter Sent** ☐ **N/A**
32. ☐ **Arrest Record from Company**
33. ☐ **Employee Not Attending New Empl Orientation(Temp, PT, etc.):** ☐ **N/A**
☐ **View VIWP/Sexual Harassment Video & Sign Acknowl. Receipt** ☐ **N/A**
OR
☐ **NEO Video (Spanish Only Speaking) & Sign Acknowl. Receipt** ☐ **N/A**

Personnel Representative Signature _____

Send completed forms to:
Florida New Hire Reporting Center
PO Box 6500
Tallahassee, FL 32314-6500
Fax: (850) 656-0528 or toll-free fax 1 (888) 854-4762

| | | |
|---|---|---|
| A | B | C |
|---|---|---|

Federal Employer ID Number (FEIN) (Please use the same FEIN that appears on your quarterly wage reports you submit to the State):

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Is medical insurance available to employee? Y/N

Florida Employer Unemployment Compensation (UI) Number:

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| | | | | | | | |
|--|--|--|--|--|--|--|--|

Employer Name:

[illegible]

Employer Address: (Please indicate the address where the Income Deduction Orders should be sent).

[illegible][illegible]

Employer City:

Employer State: Zip Code (5 digit):

| | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
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Employer State:

Zip Code (5 digit)

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Employer Phone:

Extension:

Employer Fax:

| | | | |
|--|--|--|--|
| | | | |
|--|--|--|--|

Email:

[illegible]

Employee Social Security Number (SSN):

| | | |
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Employee First Name:

[illegible]

Middle Initial:

Employee Last Name:

Employee Address:

[illegible]

Employee City:

Employee State: Zip Code (5 digit):

Date of Hire:

| | | | | | | | | | | | | | | |
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Employee State:

| | |
|--|--|
| | |
|--|--|

 Zip Code (5 digit):

| | | | | |
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Date of Hire:

Date of Birth:

| | | | | |
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Reports must be submitted within 20 days of date of hire or rehire

REPORTS WILL NOT BE PROCESSED IF REQUIRED INFORMATION IS MISSING

Questions? Call us at (850) 656-3343 or toll-free 1 (888) 854-4791

Rev (08/02)

EMPLOYEE NAME: _____

IN CASE OF EMERGENCY NOTIFY:

NAME: _____

ADDRESS: _____

PHONE: _____

RELATIONSHIP: _____

2nd Contact (If above cannot be reached)

NAME: _____

ADDRESS: _____

PHONE: _____

RELATIONSHIP: _____

CRIMINAL BACKGROUND CHECK

Please be aware, a Criminal Background Check is being run on you pursuant to the County's standard operating procedure.

Should any negative/derogatory information be reported, the County has the option to withdraw it's employment offer, or if already employed, terminate your employment immediately.

Once employed, the County may request a Criminal Background Check (for employment purposes) at any time during the tenure of your employment.

~~~~~

I have read and understand the above, and I agree to it.

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Employee Signature

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Date

**RETIREMENT QUESTIONNAIRE**  
**MONROE COUNTY BOARD OF COUNTY COMMISSIONERS**

NAME: \_\_\_\_\_ SS# \_\_\_\_\_

**SPECIAL RISK EMPLOYEES ONLY** (Firefighter/Paramedic, Firefighter/EMT, Paramedic, EMT):

Was your last employment retirement plan with any other plan other than HA (Regular Class)

☐ YES      ☐ NO

*OR*

Are you a re-employed retiree

☐ YES      ☐ NO.

If either or both is YES, employee must fill out an FRS-M10 Personal History Record.



## Florida Retirement System (FRS) New Employee Certification Form

**EMPLOYEES: PLEASE COMPLETE AND SIGN THE BOTTOM OF THIS FORM.**

I. Name \_\_\_\_\_ SSN# \_\_\_\_\_  
Agency Name \_\_\_\_\_ Hire Date \_\_\_\_\_  
Previous FRS Employer \_\_\_\_\_ Termination Date \_\_\_\_\_

Check one to indicate your previous State of Florida administered retirement plan: None \_\_\_\_\_  
FRS Pension Plan \_\_\_ FRS Investment Plan \_\_\_ DROP \_\_\_ TRS \_\_\_ SCOERS \_\_\_ Other (See Note 2 below) \_\_\_

II. I **am not retired**<sup>1</sup> from any State of Florida administered retirement plan nor have I concluded participation in the Deferred Retirement Option Program (DROP) within the past 12 months. I understand that:

- If I do not enroll in one of the two employer-paid FRS retirement plans by my deadline, I will **default** to the FRS Pension Plan. My enrollment deadline is 4:00 p.m. ET of the last business day of the 5<sup>th</sup> month following my month of hire.<sup>2</sup>
- I will qualify for a benefit ("vest") in the FRS Pension Plan after **6 years** of FRS service and in the FRS Investment Plan after **1 year** of service.<sup>3</sup>
- I can get free help on the toll-free MyFRS Financial Guidance Line (1-866-44-MyFRS) and FRS web site ([www.MyFRS.com](http://www.MyFRS.com)). I will also get an FRS Retirement Choice kit mailed to my home.
- After I make my first FRS plan selection, I will have one more opportunity to switch FRS plans ("2<sup>nd</sup> election"). I must work in the month after my "2<sup>nd</sup> Election" is processed for the plan change to be effective.

III. I **am retired**<sup>1</sup> from the \_\_\_\_\_ Retirement System. The effective date of my retirement, conclusion of DROP, or first distribution from the FRS Investment Plan was \_\_\_\_\_. I understand that:

- If I retired or participated in DROP under a State of Florida administered retirement plan and I am employed in any type of position (OPS, temporary, part-time, or regularly established) during my first calendar month of retirement, my retirement and DROP is void, all retirement and DROP benefits received **must be repaid**, and I must reapply for retirement benefits before my retirement will be effective.
- If I am reemployed at any time from the 2<sup>nd</sup> through 12<sup>th</sup> month after retirement or conclusion of DROP, my monthly retirement benefit **must be suspended** during these months of my retirement, unless I am eligible for one of the reemployment exemptions provided by law.
- If I am eligible for the exemption that limits reemployment to 780 hours, my benefits must be suspended after my employment reaches 780 hours during the limitation period.
- Rehired retirees** are eligible for the FRS retirement plan choices and free resources described in Part II.

Signature \_\_\_\_\_ Date \_\_\_\_\_

<sup>1</sup> You are retired if you are receiving monthly benefits under the FRS Pension Plan or have taken any distribution under the FRS Investment Plan or optional non-FRS plans (e.g., CCORP, SUSORP, or SMSOAP; see Note 2 below).

<sup>2</sup> If you are not retired and earned FRS service after certain periods in 2002 (depending on your employer), you must rejoin the FRS retirement plan you were enrolled in when you terminated FRS-covered employment. You may have a one-time 2<sup>nd</sup> Election to switch FRS retirement plans. Also, non-FRS plans are available to certain State University (i.e., SUSORP), Community College (i.e., CCORP) and State Senior Management Class (i.e., SMSOAP) employees. Contact your employer for deadline and other information.

<sup>3</sup> Any FRS Pension Plan service transferred into the FRS Investment Plan will vest in 6 years.

**EMPLOYERS: RETAIN THIS FORM IN THE EMPLOYEE'S PERSONNEL FILE. DO NOT SEND THIS FORM TO THE FRS, UNLESS REQUESTED.**

Florida Retirement System Pension Plan  
Beneficiary Designation Form  
Active Members Only



PO Box 9000  
Tallahassee FL 32315-9000

|                     |                     |                      |                                    |
|---------------------|---------------------|----------------------|------------------------------------|
| _____<br>Last Name  | _____<br>First Name | _____<br>Middle Name | _____<br>Member SSN:               |
| _____<br>Prior Name | _____<br>First Name | _____<br>Middle Name | _____<br>Birthdate                 |
|                     |                     |                      | _____<br>Female/Male<br>Circle One |

**DESIGNATION OF BENEFICIARIES - COMPLETE ONLY SECTION 1, 2, OR 3**

**REEMPLOYED RETIREES** - Completion of this section will not change the beneficiary on your retired account. This beneficiary designation is for your renewed membership under FRS Pension Plan only. Obtain Form FST-12 from the Division of Retirement if you wish to change the beneficiary on your retired account. **Only a beneficiary who qualifies as joint annuitant will be eligible for a monthly benefit upon your death.**

**DROP PARTICIPANTS** - Do not use this form to change your beneficiary. Obtain Form FST-12 from the Division of Retirement.

**1. I CHOOSE TO HAVE BENEFITS PAID IN ACCORDANCE WITH 121.091(8), F.S., AS FOLLOWS:**

**FRS PENSION PLAN MEMBERS ONLY** - Benefits from your account to be paid: 1st to your spouse, 2nd to your living children (equally), 3rd to your parents (equally), and 4th to the legal representative of your estate (see below). If you are not survived by a spouse, the names of your survivors must be documented by court order. If you do not want your benefits paid in this manner in the event of your death, complete either Section 2 or 3.

**TRS & SCOERS MEMBERS** - You must name a beneficiary either Sequentially or Jointly.

OR

**\*\*\* TYPE OR PRINT THE FOLLOWING SECTIONS \*\*\***

**2. SEQUENTIALLY (IN ORDER NAMED)** - Do not list a beneficiary here if above section is completed. Benefits will be paid to the first named beneficiary.

|                                        |                       |                    |                 |
|----------------------------------------|-----------------------|--------------------|-----------------|
| _____<br>Primary Beneficiary           | _____<br>Relationship | _____<br>Birthdate | _____<br>Gender |
| _____<br>First Contingent Beneficiary  | _____<br>Relationship | _____<br>Birthdate | _____<br>Gender |
| _____<br>Second Contingent Beneficiary | _____<br>Relationship | _____<br>Birthdate | _____<br>Gender |

OR

**3. JOINTLY** - Benefits shall be divided and payable as indicated below (percentages should total 100%).

|                              |                       |                    |                 |            |
|------------------------------|-----------------------|--------------------|-----------------|------------|
| _____<br>Primary Beneficiary | _____<br>Relationship | _____<br>Birthdate | _____<br>Gender | _____<br>% |
| _____<br>Primary Beneficiary | _____<br>Relationship | _____<br>Birthdate | _____<br>Gender | _____<br>% |
| _____<br>Primary Beneficiary | _____<br>Relationship | _____<br>Birthdate | _____<br>Gender | _____<br>% |

If the above does not meet your needs, attach a signed and dated listing of your designated beneficiaries (in the above format). Please include the relationship, birthday, gender, and percentage for each designated beneficiary.

|                           |                                     |               |
|---------------------------|-------------------------------------|---------------|
| _____<br>Member Signature | _____<br>Agency Number/ Agency Name | _____<br>Date |
|---------------------------|-------------------------------------|---------------|

**DESIGNATION OF BENEFICIARY - FRS PENSION PLAN ONLY:** Section 121.091(8), Florida Statutes, provides: "Each member may, on a form provided for that purpose, signed and filed with the Division, designate a choice of one or more persons, named sequentially or jointly, as his or her beneficiary who shall receive the benefits, if any, which may be payable in the event of the member's death pursuant to the provisions of this chapter. If no beneficiary is named in the manner provided above, or if no beneficiary designated by the member survives the member, the beneficiary shall be the spouse of the deceased, if living. If the member's spouse is not alive at his or her death, the beneficiary shall be the living children of the member. If no children survive, the beneficiary shall be the member's father or mother, if living; otherwise, the beneficiary shall be the member's estate."

If your designated beneficiary does not qualify as a joint annuitant, only a refund of any contributions you made to the system will be paid at your death. Only a joint annuitant will be eligible to receive monthly benefits from your retirement account. A joint annuitant is your spouse; your natural or legally adopted child who is either under age 25 or is physically or mentally disabled and incapable of self-support (regardless of age); or your parent, grandparent, or a person for whom you are the legal guardian, provided such parent, grandparent, or person received one-half or more of their financial support from you or is eligible to be claimed as a dependent on your federal income tax return. **Effective January 1, 1999, a member's spouse will be the primary beneficiary regardless of previous beneficiary designations unless a new Form BEN-001 is completed subsequent to the marriage to the current spouse.**

**TRS or SCOERS MEMBERS:** You must name a beneficiary to receive, sequentially or jointly, any benefits that may be payable upon your death prior to retirement. You may name as your beneficiary any person, organization, your estate or trust, but only your spouse is eligible to receive a monthly benefit if you die prior to your actual retirement after completing 10 years of creditable service.

You should keep your beneficiary designations current at all times. Any questions on designating beneficiaries should be directed to the Division by writing: Division of Retirement, ATTN: Enrollment Section, PO Box 9000, Tallahassee, FL 32315-9000 or by calling 850/488-8837, SUNCOM 278-8837.

**ID BADGE INFORMATION**  
**Picture will be taken when completed**

**EMPLOYEE'S NAME** \_\_\_\_\_

**DEPARTMENT** \_\_\_\_\_

**POSITION TITLE** \_\_\_\_\_

**DEPARTMENT PHONE #** \_\_\_\_\_

**HEIGHT** \_\_\_\_\_ **WEIGHT** \_\_\_\_\_

**HAIR COLOR** \_\_\_\_\_ **EYE COLOR** \_\_\_\_\_

**DATE OF BIRTH** \_\_\_\_\_

**PICTURE TAKEN:** ☐ YES ☐ NO

\*If picture is not taken at the time  
employee fills out new hire paperwork  
the employee is required to take photo  
in Personnel Office-KW while attending  
New Employee Orientation.

☐ PK ☐ MAR ☐ KW

**ID BADGES WILL BE DISTRIBUTED ON OR BEFORE THE  
EMPLOYEE'S ORIENTATION DATE. IF THERE IS AN  
EMERGENCY NEED BEFORE THIS TIME DUE TO JOB  
REQUIREMENTS, PLEASE NOTIFY PAM x4461.**

**EMPLOYEE MUST RETURN ID BADGE TO PERSONNEL UPON  
SEPARATION FROM COUNTY EMPLOYMENT.**

**I have read and understand the above:**

\_\_\_\_\_  
**Employee Signature**

\_\_\_\_\_  
**Date**



Welcome new employee!

We would like to introduce you to your co-workers in our bi-monthly County newsletter – HR Link. Your picture along with your title and other information that you provide to us below will be featured. Please take the time to complete the below questions. It is not necessary to provide answers to each question.

Any prior job history that you wish your fellow employees to know about you?

Any prior education that you wish your fellow employee's to know?

Do you have any community involvement (memberships, boards, etc.) that you wish to provide?

Anything else you wish to let us know about yourself?

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Department Name: \_\_\_\_\_

Location: \_\_\_\_\_

☐ PICTURE TAKEN:

☐ Digital – KW

☐ Polaroid – Middle & Upper Keys

☐ GIVE TO PAM TO SCAN

**Employer, remove this page**

Please fill out the below information. This information will be utilized for the annual EEO-4 report that is required by State and Local Government Agencies and other governmental surveys. This information will be kept separate from your employment application and/or personnel file. Completion of this form is voluntary.

Please check below:

EMPLOYEE ☐

APPLICANT ☐

DATE: \_\_\_\_\_

POSITION TITLE FOR WHICH YOU ARE APPLYING \_\_\_\_\_

**MALE APPLICANTS:**

|    |                                      |                          |
|----|--------------------------------------|--------------------------|
| AA | WHITE MALE, NON-HISPANIC             | <input type="checkbox"/> |
| AB | BLACK MALE, NON-HISPANIC             | <input type="checkbox"/> |
| AC | WHITE MALE, HISPANIC                 | <input type="checkbox"/> |
| AD | BLACK MALE, HISPANIC                 | <input type="checkbox"/> |
| AE | ASIA OR PACIFIC ISLANDER, MALE       | <input type="checkbox"/> |
| AF | AMERICAN INDIAN/ALASKAN NATIVE, MALE | <input type="checkbox"/> |

**FEMALE APPLICANTS:**

|    |                                        |                          |
|----|----------------------------------------|--------------------------|
| BA | WHITE FEMALE, NON-HISPANIC             | <input type="checkbox"/> |
| BB | BLACK FEMALE, NON-HISPANIC             | <input type="checkbox"/> |
| BC | WHITE FEMALE, HISPANIC                 | <input type="checkbox"/> |
| BD | BLACK FEMALE, HISPANIC                 | <input type="checkbox"/> |
| BE | ASIA OR PACIFIC ISLANDER, FEMALE       | <input type="checkbox"/> |
| BF | AMERICAN INDIAN/ALASKAN NATIVE, FEMALE | <input type="checkbox"/> |

OTHER \_\_\_\_\_

**MONROE COUNTY POLICIES AND PROCEDURES MANUAL**  
**ACKNOWLEDGEMENT AND RECEIPT**

1. GENERAL. The Personnel Policies and Procedures Manual, which may from time to time be referred to as the PPM, is provided to serve as a general guide for employees during their tenure with Monroe County.

a. PPM is not intended to create, nor shall it be construed to create or be interpreted as, a contract of employment – either express or implied – between the County and the employee. Any language in the PPM which is in apparent conflict with the intent of this “no contract” provision shall be interpreted and applied consistent with this “no contract” provision.

b. Additionally, as changes in circumstances occur and unique situations arise, changes in the PPM and its interpretation may be required and, therefore, this PPM is subject to immediate change without notice; however, reasonable efforts will be made to notify employees in writing as soon as practical of changes to the PPM.

c. Information in the PPM concerning employee benefits is intended to briefly summarize certain aspects of the benefits available to employees. For a more detailed description of available benefits and procedures to be followed, the employee should consult the benefit plan documents. The provisions of the plan documents will supersede and prevail over any inconsistent provisions of the PPM.

2. ACKNOWLEDGEMENT. By signing this form below, I acknowledge that (a) I have received a written copy of the Monroe County Personnel Policies and Procedures Manual; (b) I will have ten (10) working days from receipt of the PPM to read and review it, and to contact the Administrator of Personnel or designee to obtain answers to any questions I may have about the PPM and its contents; (c) I will be considered to understand the PPM and its contents if I do not ask any questions during the ten (10) days following receipt of the PPM; and (d) I understand and agree that I have read this form, understand what it says, and I understand and agree that the PPM does not create a contract of employment between Monroe County and me.

\_\_\_\_\_  
Printed Name of Applicant/Employee

\_\_\_\_\_  
Signature of Applicant/Employee

\_\_\_\_\_  
Signature of Witness

Date of Signing: \_\_\_\_\_

FOR QUESTIONS CONCERNING THE PPM, YOU MAY CONTACT:

Name: Teresa E. Aguiar - Personnel

Telephone: (305) 292-4458

E-Mail: Aguiar-Teresa@MONROECOUNTY-FL.GOV

PUBLIC RECORDS  
F.S. CHAPTER 119.07

Your social security number, medical records, deferred compensation information, direct deposit information along with other information (as specified in other statutes) is not to be released to the general public.

In accordance with this law (F.S. Chapter 119.07), certain additional information as noted below, is exempt from disclosure to the general public if you are any of the following:

The home address, telephone number, and photograph:

☐ **Active or former law enforcement personnel, including correctional probation officers OR spouse and children of such personnel.**

The home address, telephone number, and photograph:

☐ **Certified Firefighters OR spouse and children of such.**

The home address, telephone number, places of employment and photograph:

☐ **Current or Former Guardian ad Litem employees or spouse and children of such. (*"...shall stand repealed on October 2, 2010, unless reviewed and saved from repeal through reenactment by the Legislature."*).**

The home address, telephone number, and photograph:

☐ **Current or former state attorneys, assistant state attorneys, statewide prosecutors, or assistant statewide prosecutors OR spouse and children of such personnel.**

The home address, telephone number, and photograph:

☐ **Current or former human resource, labor relations, or employee relations directors, assistant directors, managers, or assistant managers of any local government agency or water management district whose duties include hiring and firing employees, labor contract negotiation, administration, or other personnel-related duties OR spouse and children of such personnel (*"...shall stand repealed on October 2, 2006, unless reviewed and saved from repeal through reenactment by the Legislature."*).**

The home address, telephone numbers, and photograph:

☐ **Current or former code enforcement officers OR spouse and children of such personnel (*"...shall stand repealed on October 2, 2006, unless reviewed and saved from repeal through reenactment by the Legislature."*).**

☐ **None of the above pertain to me at this time.**

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

# Form W-4 (2006)

**Purpose.** Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Because your tax situation may change, you may want to refigure your withholding each year.

**Exemption from withholding.** If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2006 expires February 16, 2007. See Pub. 505, Tax Withholding and Estimated Tax.

**Note.** You cannot claim exemption from withholding if (a) your income exceeds \$850 and includes more than \$300 of unearned income (for example, interest and dividends) and (b) another person can claim you as a dependent on their tax return.

**Basic instructions.** If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-

earner/two-job situations. Complete all worksheets that apply. However, you may claim fewer (or zero) allowances.

**Head of household.** Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See line E below.

**Tax credits.** You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

**Nonwage income.** If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax.

**Two earners/two jobs.** If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others.

**Nonresident alien.** If you are a nonresident alien, see the Instructions for Form 8233 before completing this Form W-4.

**Check your withholding.** After your Form W-4 takes effect, use Pub. 919 to see how the dollar amount you are having withheld compares to your projected total tax for 2006. See Pub. 919, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

**Recent name change?** If your name on line 1 differs from that shown on your social security card, call 1-800-772-1213 to initiate a name change and obtain a social security card showing your correct name.

## Personal Allowances Worksheet (Keep for your records.)

- A** Enter "1" for **yourself** if no one else can claim you as a dependent. **A** \_\_\_\_\_
- B** Enter "1" if: **B** \_\_\_\_\_
- You are single and have only one job; or
  - You are married, have only one job, and your spouse does not work; or
  - Your wages from a second job or your spouse's wages (or the total of both) are \$1,000 or less.
- C** Enter "1" for your **spouse**. But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) **C** \_\_\_\_\_
- D** Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return **D** \_\_\_\_\_
- E** Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) **E** \_\_\_\_\_
- F** Enter "1" if you have at least \$1,500 of **child or dependent care expenses** for which you plan to claim a credit **F** \_\_\_\_\_
- (**Note.** Do not include child support payments. See **Pub. 503**, Child and Dependent Care Expenses, for details.)
- G** **Child Tax Credit** (including additional child tax credit): **G** \_\_\_\_\_
- If your total income will be less than \$55,000 (\$82,000 if married), enter "2" for each eligible child.
  - If your total income will be between \$55,000 and \$84,000 (\$82,000 and \$119,000 if married), enter "1" for each eligible child plus "1" **additional** if you have four or more eligible children.
- H** Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) **H** \_\_\_\_\_
- For accuracy, complete all worksheets that apply. **Deductions**
- If you plan to **itemize or claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
  - If you have **more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed \$35,000 (\$25,000 if married) see the **Two-Earner/Two-Job Worksheet** on page 2 to avoid having too little tax withheld.
  - If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

Cut here and give Form W-4 to your employer. Keep the top part for your records.

|                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                       |  |                                         |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------|
| <b>Form W-4</b>                                                                                                                                                                                                                                                                                                                                                                                                                               |  | <b>Employee's Withholding Allowance Certificate</b>                                                                                                                                                                                                   |  | OMB No. 1545-0074                       |
| Department of the Treasury<br>Internal Revenue Service                                                                                                                                                                                                                                                                                                                                                                                        |  | ▶ <b>Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.</b>                                        |  |                                         |
| <b>2006</b>                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                       |  |                                         |
| 1 Type or print your first name and middle initial. Last name                                                                                                                                                                                                                                                                                                                                                                                 |  | 2 Your social security number                                                                                                                                                                                                                         |  |                                         |
| Home address (number and street or rural route)                                                                                                                                                                                                                                                                                                                                                                                               |  | 3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate.<br><b>Note.</b> If married, but legally separated, or spouse is a nonresident alien, check the "Single" box. |  |                                         |
| City or town, state, and ZIP code                                                                                                                                                                                                                                                                                                                                                                                                             |  | 4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a new card. <input type="checkbox"/>                                                                                           |  |                                         |
| 5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)                                                                                                                                                                                                                                                                                                                                  |  | 5 _____                                                                                                                                                                                                                                               |  |                                         |
| 6 Additional amount, if any, you want withheld from each paycheck                                                                                                                                                                                                                                                                                                                                                                             |  | 6 \$ _____                                                                                                                                                                                                                                            |  |                                         |
| 7 I claim exemption from withholding for 2006, and I certify that I meet <b>both</b> of the following conditions for exemption.<br>• Last year I had a right to a refund of <b>all</b> federal income tax withheld because I had <b>no</b> tax liability and<br>• This year I expect a refund of <b>all</b> federal income tax withheld because I expect to have <b>no</b> tax liability.<br>If you meet both conditions, write "Exempt" here |  | 7 _____                                                                                                                                                                                                                                               |  |                                         |
| Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete.                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                       |  |                                         |
| Employee's signature<br>(Form is not valid unless you sign it.) ▶                                                                                                                                                                                                                                                                                                                                                                             |  | Date ▶                                                                                                                                                                                                                                                |  |                                         |
| 8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)                                                                                                                                                                                                                                                                                                                                                 |  | 9 Office code (optional)                                                                                                                                                                                                                              |  | 10 Employer identification number (EIN) |

## **DIRECTIONS FOR PERSONNEL REPRESENTATIVE IN COMPLETING I-9 FORM**

- ☐ 1. **Ask the post-offer applicant for any identification he/she chooses to provide as stated on the back of the I-9 form.** Either 1 form or identification from column "A" OR 1 from column "B" and 1 from column "C". Do not specifically ask for certain documents in completing this form .
- ☐ 2. **The post-offer applicant MUST complete Section 1 on his/her own.** If the Personnel Representative completes (i.e. in the case of a translator), then the section below the signature must be completed by the Representative or Translator.
- ☐ Ensure that the "Last" Name is written first and not the "First" name.
- ☐ Address must be "Street Address". P.O. Box is not acceptable.
- ☐ No Nicknames – Only Proper name should be written.
- ☐ 3. NO marks such as "X" for signature, 'scratch thru's' or white-out on the form!
- ☐ 4. **Section 2: Document Title and Issuing authority must be spelled out.**  
Example: "DMV" IS NOT correct "Department of Motor Vehicles" is correct.
- ☐ 5. If using Social Security card as Identification, READ the back of the card. The issuing authority should read "US Department of Health and Rehabilitative Services" or other such name -"Social Security Administration". ENSURE THAT ALL DOCUMENTS USED FOR SECTION 2 ARE APPROPRIATELY REVIEWED FOR THE APPROPRIATE "ISSUING AUTHORITY" AND "TITLE".
- ☐ 6. If document does not have an expiration date, mark "N/A"
- ☐ 7. Receipt of application used.
- ☐ Personnel Representative in Key West must ensure actual document within 90 days of the date of employment began (tickler).
- ☐ Document Received: Draw line through "Receipt" and any accompanying document # and insert new information. Date and initial changes.
- ~~~~~

I have ensured that the above has been followed:

\_\_\_\_\_  
Personnel Representative

Please read instructions carefully before completing this form. The instructions must be available during completion of this form. **ANTI-DISCRIMINATION NOTICE.** It is illegal to discriminate against work eligible individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.

**Section 1. Employee Information and Verification.** To be completed and signed by employee at the time employment begins

|                                  |       |          |                |                                |
|----------------------------------|-------|----------|----------------|--------------------------------|
| Print Name: Last                 |       | First    | Middle Initial | Maiden Name                    |
| Address (Street Name and Number) |       |          | Apt. #         | Date of Birth (month/day/year) |
| City                             | State | Zip Code |                | Social Security #              |

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

☐ A citizen or national of the United States

☐ A Lawful Permanent Resident (Alien # A \_\_\_\_\_)

☐ An alien authorized to work until \_\_\_\_\_  
(Alien # or Admission # \_\_\_\_\_)

Employee's Signature \_\_\_\_\_ Date (month/day/year) \_\_\_\_\_

**Preparer and/or Translator Certification.** (To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

|                                                               |                  |
|---------------------------------------------------------------|------------------|
| Preparer's/Translator's Signature _____                       | Print Name _____ |
| Address (Street Name and Number, City, State, Zip Code) _____ |                  |
| Date (month/day/year) _____                                   |                  |

**Section 2. Employer Review and Verification.** To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C as listed on the reverse of this form and record the title, number and expiration date, if any, of the document(s)

| List A                          | OR | List B | AND | List C |
|---------------------------------|----|--------|-----|--------|
| Document title: _____           |    | _____  |     | _____  |
| Issuing authority: _____        |    | _____  |     | _____  |
| Document #: _____               |    | _____  |     | _____  |
| Expiration Date (if any): _____ |    | _____  |     | _____  |
| Document #: _____               |    | _____  |     | _____  |
| Expiration Date (if any): _____ |    | _____  |     | _____  |

**CERTIFICATION - I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on (month/day/year) \_\_\_\_\_ and that to the best of my knowledge the employee is eligible to work in the United States. (State employment agencies may omit the date the employee began employment).**

|                                                          |                                                               |                             |
|----------------------------------------------------------|---------------------------------------------------------------|-----------------------------|
| Signature of Employer or Authorized Representative _____ | Print Name _____                                              | Title _____                 |
| Business or Organization Name _____                      | Address (Street Name and Number, City, State, Zip Code) _____ | Date (month/day/year) _____ |

MONROE COUNTY BOCC 1100 Simonton St. 2nd floor, Key West, FL 33040

**Section 3. Updating and Reverification.** To be completed and signed by employer

|                                                                                                                                                                    |                                                          |                                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|---------------------------------|
| A. New Name (if applicable) _____                                                                                                                                  | B. Date of rehire (month/day/year) (if applicable) _____ |                                 |
| C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility. |                                                          |                                 |
| Document Title: _____                                                                                                                                              | Document #: _____                                        | Expiration Date (if any): _____ |

I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

|                                                          |                             |
|----------------------------------------------------------|-----------------------------|
| Signature of Employer or Authorized Representative _____ | Date (month/day/year) _____ |
|----------------------------------------------------------|-----------------------------|



Monroe County Administrative Services  
Personnel  
1100 Simonton Street 2nd Floor  
Key West, FL 33040



**BOARD OF COUNTY COMMISSIONERS**

MAYOR Dixie M. Spehar, District 1  
Mayer Pro Tem Murray E. Nelson, District 5  
George Neugent, District 2  
Charles "Sonny" McCoy, District 3  
David P. Rice, District 4



OFFICE OF THE COUNTY ADMINISTRATOR  
Key West, Florida

MONROE COUNTY ADMINISTRATIVE INSTRUCTION 1003.9

Date: April 16, 2003

Subject: Purchase, Travel, Pay, Personnel & Safety Action Authorization

Reference: (A) M.C.A. Inst. 4801: Purchasing Policies & Procedures  
(B) Monroe County Safety Policies & Procedures (Employee Handout)  
(C) Monroe County Administrative Order #1-19

Enclosure: (1) Document Approval List  
(2) Voucher for Reimbursement of Travel Expenses  
(3) Form 1003.9, Employee Acknowledgment Document

Effective Date: Upon Receipt

- (1) Background: In the administration of County Government, it is necessary for certain employees to originate, review and approve various documents in order to authorize the many actions that are required in the conduct of the daily business of this County. It is incumbent upon all Monroe County employees to be knowledgeable of the policies, procedures and document approval authority as provided by the Monroe County Board of County Commissioners and the County Administrator.
- (2) Purpose: The purpose of this instruction is to promulgate the policy, procedures and authority to be adhered to by Monroe County employees with regard to originating, reviewing and approving the many various official documents and actions that are required in the routine administration of Monroe County Government.
- (3) Cancellation: This instruction is to remain continuously in effect unless specifically revised or canceled.



(4) Instructions:

- A. All employees are responsible for being knowledgeable of, and for adherence to, the purchasing policies and procedures (Reference (A) ).
- B. The Appendix to Reference (A) promulgates Enclosure (1), the "Document Approval List". This List provides for recommendation, initiation and approval authority for originating and approving various Monroe County personnel action, purchasing and travel authority documents. Strict adherence to same is required by all applicable employees.
- C. All employees are reminded, as promulgated therein, that all out of Monroe County travel requiring overnight lodging must have the prior approval of the Division Director or County Administrator. In Monroe County travel requiring overnight lodging will require the approval of the Department Head.
- D. If travel is to any County contiguous with Monroe County or if the travel can be completed within one work day not requiring overnight lodging, prior approval of the next highest supervisory level can be obtained.
- E. Reference (B) was adopted by the MCBOCC and became effective April, 1998. All employees are responsible for being knowledgeable of, and for adherence to, the safety policies and procedures contained therein.
- F. Reference (C) is augmented and superseded by References (A), and this instruction.
- G. All requests for travel reimbursement shall be submitted in writing on voucher form (Enclosure 2) which shall give date(s) of travel, purpose, all applicable receipts, and amount due the traveler. Advance payment for travel must be requested by submitting voucher form for approval by the applicable Division Director or County Administrator.
- H. Travel shall be the most economical and practicable method available. Authorization for a rental car must be requested in advance and approved by the applicable Division Director or County Administrator.

(5) Action:

- A. Division Directors, Department Heads and applicable Supervisory Personnel are themselves responsible for, and insuring the employees falling under their purview are also knowledgeable of and strictly adhere to, the policies and procedures promulgated by this Administrative Instruction and the referenced documents.

- B. The Personnel Office is to issue all new employees a copy of this instruction & (B). When so accomplished, Form 1003.9 (Enclosure 3) is to be signed certifying this action has been accomplished and the form subsequently permanently placed in the applicable employee's Personnel File.



James L. Roberts  
County Administrator

Distribution: List III

Originator: HRD

Review: 04.16.06

DOCUMENT APPROVAL LIST

| DOCUMENT |                                                                                                            | COUNTY<br>ADMINISTRATOR | DIVISION<br>DIRECTOR | DEPARTMENT<br>HEAD | SUPERVISOR |
|----------|------------------------------------------------------------------------------------------------------------|-------------------------|----------------------|--------------------|------------|
| 1.       | Time Sheets, Normal                                                                                        |                         |                      | Approval           | Recommend  |
| 2.       | Time Sheets -- NON-EXEMPT                                                                                  |                         |                      | Approval           | Initiate   |
|          | Regular, Overtime, Comp Time                                                                               |                         |                      |                    |            |
| 3.       | Time Sheets -- EXEMPT                                                                                      |                         |                      | Approval           | Initiate   |
|          | Regular Time, No Paid OT or CT                                                                             |                         |                      |                    |            |
| 4.       | Time Sheets (Paid OT, CT) Exempt Employees, *LWOP                                                          | Approval                | Recommend            | Initiate           |            |
| 5.       | Leave Requests: VT, SL, Jury, Death Leave                                                                  |                         |                      | Approval           | Recommend  |
| 6.       | Leave of Absence                                                                                           | Approval                | Recommend            | Initiate           |            |
| 7.       | Written/Oral Warning/Reprimand                                                                             | Approval                | Recommend            | Recommend          | Initiate   |
| 8.       | Personnel Action Form:                                                                                     | Approval                | Recommend            | Recommend          | Initiate   |
| 9.       | Hire (Grade 10 and above)                                                                                  | Approval                | Recommend            | Recommend          | Initiate   |
| 10.      | Termination                                                                                                | Approval                | Recommend            | Initiate           |            |
| 11.      | Reclassification                                                                                           | Approval                | Recommend            | Initiate           |            |
| 12.      | Promotion (Grade 10 and above)                                                                             | Approval                | Recommend            | Initiate           |            |
| 13.      | Demotion                                                                                                   | Approval                | Recommend            | Initiate           |            |
| 14.      | Suspension                                                                                                 | Approval                | Recommend            | Initiate           |            |
| 15.      | Salary Increase                                                                                            | Approval                | Recommend            | Initiate           |            |
| 16.      | Travel -- Overnight Lodging<br>In-Monroe County                                                            |                         |                      |                    |            |
|          | Out-of-Monroe County                                                                                       | Approval                | Approval             | Approval           |            |
| 17.      | Travel -- NO Overnight Lodging<br>County Contiguous with Monroe County<br>Completed within one (1) workday |                         |                      |                    | Approval   |
| 18.      | Invoice/Audit Slips under \$5,000                                                                          |                         |                      |                    |            |
| 19.      | Contract/leases/agreements under \$1,000                                                                   | Approval                | Recommend            | Approval           | Initiate   |
| 20.      | Invoice/Audit Slips \$5,000-\$10,000                                                                       |                         | Approval             | Recommend          |            |
| 21.      | Contracts/leases/agreements \$1,000-\$10,000                                                               | Recommend               | Recommend            | Initiate           |            |
| 22.      | Invoice/Audit Slips \$10,000-\$25,000                                                                      | Approval                | Recommend            | Initiate           |            |
| 23.      | Contracts/leases/agreements \$10,000-\$25,000                                                              | Recommend               | Recommend            | Initiate           |            |
| 24.      | Invoice/Audit Slips over \$25,000                                                                          | Recommend               | Recommend            | Initiate           |            |
| 25.      | Contracts/leases/agreements over \$25,000                                                                  | Recommend               | Recommend            | Initiate           |            |
| 26.      | Intra-Dept. Budget Transfer                                                                                | Recommend               | Recommend            | Initiate           |            |
| 27.      | Inter-Dept. Budget Transfer                                                                                | Recommend               | Recommend            | Initiate           |            |
| 27.      | Purchase Order # (See Purchasing Policies and Procedures)                                                  | Approval                | Recommend            |                    |            |

\*LWOP -- Short term: up to 5 days.

(any longer is leave of absence -- see #6)

AGENCY \_\_\_\_\_  
HEADQUARTERS \_\_\_\_\_

[illegible]

**Travel Performed by Common Carrier or State Vehicle**

*This section required to be completed only when common carrier is billed directly to the state agency.*

| Date | Ticket Number or<br>State Vehicle Number | From | To | Amount | Name of Common Carrier or<br>State Agency Owning Vehicle |
|------|------------------------------------------|------|----|--------|----------------------------------------------------------|
|      |                                          |      |    |        |                                                          |
|      |                                          |      |    |        |                                                          |
|      |                                          |      |    |        |                                                          |
|      |                                          |      |    |        |                                                          |
|      |                                          |      |    |        |                                                          |

**GENERAL INSTRUCTIONS**

Class A Travel—Continuous travel of 24 hours or more away from official headquarters.

Class B Travel—Continuous travel of less than 24 hours which involves overnight absence from official headquarters.

Class C Travel—Travel for short or day trips where the traveler is not away from his official headquarters overnight.

NOTE: No allowance shall be made for meals when travel is confined to the city or town of official headquarters or immediate vicinity except assignments of official business outside the traveler's regular place of employment if travel expenses are approved and such special approval is noted on the travel voucher. Rates of Per Diem and Meals shall be those prescribed by Section 112.061, Florida Statutes.

Per Diem shall be computed at one-fourth of authorized rate for each quarter of fraction thereof. Travel over a period of 24 hours or more will be calculated on the basis of 6-hour cycles, beginning at midnight; less than 24-hour travel will be calculated on the basis of 6-hour cycles, beginning at the hour of departure from official headquarters. Hour of departure and hour of return should be shown for all travel. When claiming per diem, the meal allowance columns should not be used.

Claims for actual lodging at the single occupancy rate plus meal allowances should include the commercial lodging expenses in the "Per Diem or Actual Lodging Expenses" column and include the appropriate meal allowances in the "Meals for Class A & B Travel" column.

Claims for meal allowances involving travel that did not require the traveler to be away from his headquarters overnight should be included in the "Class C Meals" column. Vicinity travel must appear in the separate column. When travel is by common carrier and billed directly to the traveler, the amount and description should be included in the "Other Expenses" column. A copy of the ticket or invoice should be attached to this form. If travel is by common carrier and billed directly to the State agency, then the "Travel Performed by Common Carrier or State Vehicle" section above should be completed. The name of the common carrier should be inserted in the "Map Mileage Claimed" column in these instances. Justification must be provided for use of a non-contract airline (or one offering equal or lesser rates than the contract airline) or rental car (or one having lower net rates) when contract carriers are available. Additionally, justification must be provided for use of a rental car larger than a Class "B" car.

If travel is performed by the use of a State-owned vehicle, the word "State" should be inserted in the "Map Mileage Claimed" column on the reverse side of this form, and the above section designated as "Travel Performed by Common Carrier or State Vehicle" should be completed.

Incidental travel expenses which may be reimbursed include: (a) reasonable taxi fare, (b) ferry fares and bridge, road, and tunnel tolls, (c) storage and parking fees, (d) telephone and telegraph expenses, and (e) convention or conference registration fee. If meals are included in the registration fee, per diem should be reduced accordingly. Receipts should be obtained when possible.

The official Department of Transportation map should be used in computing mileage claimed from point of origin to destination whenever possible.

If travel is complimentary, the abbreviation "Comp." Should be inserted in the "Map Mileage Claimed" column. No mileage is allowed.

When any State employee is stationed in any city or town for a period of over 30 consecutive work days, such city or town shall be deemed to be his official headquarters and he shall not be allowed per diem or subsistence after the period of 30 consecutive days has elapsed, unless extended by the approval of the agency head.

If travel is to a conference or convention, the "Statement of Benefits to the State" section must be completed or a copy of the Authorization to Incur Travel Expense, Form DBF-AA-13, must be attached. Additionally, a copy of the agenda and registration receipt must be attached.

Any fraudulent claim for mileage, per diem, or other travel expense is subject to prosecution as a misdemeanor.

GERALD LEWIS  
Comptroller

M.C.A. Inst. 1003.9  
April 16, 2003  
Page 6  
Enclosure 3

MONROE COUNTY ADMINISTRATIVE FORM 1003.9

Personnel & Safety Procedures, Purchasing, Travel, and Pay Policies; Employee Acknowledgment  
Concerning

The undersigned hereby acknowledges receiving the following documents, being instructed concerning the contents thereof, and fully comprehending the responsibility of all applicable Monroe County employees for compliance with the adherence to the policies, procedures and regulations contained therein:

1. Safety Policy & Procedures Handout (Revised 1/02)
2. Monroe County Administrative Instruction 1003.9

Name: \_\_\_\_\_

Department: \_\_\_\_\_

Position: \_\_\_\_\_

Date of Hire: \_\_\_\_\_

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date



## Monroe County Safety/Accident Prevention Policy Statement



Monroe County Administration recognizes that people are our most important assets – their safety, our greatest responsibility. We also acknowledge that as a governmental entity, it is our responsibility to provide a safe environment for the public that we serve.

Most accidents are preventable and are attributed to unsafe acts or conditions generally associated with a wasteful and/or inefficient operation. Promoting safety in the work environment is the right thing to do.

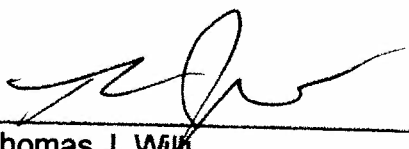
Our responsibilities, personal and resources are allocated to administer a dynamic Safety Program. The Safety Administrator has been delegated the authority of the Administrator's office to develop and coordinate the implementation of the Monroe County Safety and Accident Prevention Program. This program is designed to ensure a safe and healthful working environment for all County employees and to minimize risk to the public. However, the Safety Administrator will not be responsible for the line functions that are normally a responsibility of the Supervisor. It is expected that Division Directors and Department Heads will assist the Safety Administrator in every way, assuring that realistic efforts aimed at the reduction of accidents and injuries are continuous and equal in importance to all other operational considerations.

Our Safety and Accident Prevention Program is designed to be managed at the Division level with training, inspections, and technical assistance provided by the Safety Administrator. Every employee has an important role in the success of the accident prevention program. Management and Supervisory personnel will:

- ♦ Provide leadership and guidance to the County work force.
- ♦ Provide proper training of employees and undertake position and public "hazard" analysis in all Divisions and Departments.
- ♦ Develop proper work procedures for County operations and enforce them.
- ♦ Continuously review work practices and conditions of the work environment and public safety, seeking improvement.
- ♦ Maintain accurate records that document the above actions.

Each employee's attitude toward and participation in the Safety and Accident Prevention Program will be considered when employee evaluations are completed. Safety/Accident Prevention goals will become a part of the County's Strategic Planning Initiative.

All Monroe County employees under my direction are expected as a condition of employment to adopt the concept that the safe way to perform is the most efficient and the only acceptable way to perform a task. It is the right thing to do.

  
Thomas J. Will  
Monroe County Administrator

"Coming together is a beginning, keeping together is progress and working together is success."

# MONROE COUNTY Employees



## SAFETY RESPONSIBILITIES AND PROCEDURES

### **Mission of the Safety Office**

To reduce the cost of accidents with a comprehensive professional safety program through training, inspections and enforcement of safety policies. The Safety Office pledges to provide a safe and healthy work environment for all employees and continually improve the effectiveness of our service.



# MONROE COUNTY EMPLOYEES SAFETY RESPONSIBILITIES AND PROCEDURES

## INTRODUCTION

This handout is an excerpt from the Monroe County Safety Policies and Procedures Manual and contains employee's Safety responsibilities, general safety rules and reporting procedures. You will receive detailed Safety training in all required areas from your supervisor. The Monroe County Safety Policies and Procedures Manual is a reference document with detailed safety information that will be available to you in the work place. All supervisors and safety representatives have a copy and it is on the Monroe County Website under Employee Services, Safety Section. It contains details in the following areas:

- SAFETY RESPONSIBILITIES
- SAFETY INSPECTIONS
- DIVISION SAFETY PROGRAM
- JOB SAFETY ANALYSIS
- CRASH INVESTIGATION
- HAZARDOUS MATERIALS SAFETY PROGRAM
- LOCKOUT TAGOUT PROGRAM
- DIVE OPERATIONS
- CONFINED SPACE
- BLOODBORNE PATHOGENS
- GENERAL SAFETY RULES
- EMERGENCY OPERATIONS AND RESPONSE
- AND OTHER INFORMATION

## EMPLOYEES SAFETY RESPONSIBILITIES

Employees are required, as a condition of continued employment, to exercise due care in the course of their work to prevent injuries to themselves, their fellow workers, and the public and to conserve materials.

### *Employees will:*

1. Report all unsafe conditions and acts to their Supervisors.
2. Be individually responsible to keep themselves, fellow employees and equipment free from mishaps.
3. Keep work and storage areas neat and orderly at all times.
4. Follow prescribed procedures during an emergency.
5. Be certain that instructions are completely understood before starting work.
6. Learn to lift and handle materials properly.
7. Avoid engaging in horseplay and/or distracting others in the work environment.
8. Report immediately all injuries or property damage, no matter how minor, to their Supervisor.
9. All Employees must comply with the "Drug Free Workplace Policy"
10. Know how and where medical help may be obtained.
11. Review the safety educational material posted on bulletin boards or distributed to work areas.
12. Not damage or destroy any warning or safety device, or interfere in any way with another employee's use of them.
13. Bring a doctor's release when returning to work after a work-related injury or illness; such release must be submitted to the employee's supervisors and Workers Comp Section.
14. It should be noted that the Florida Workers Compensation Law, Section 440.0964 Florida Statutes, provides for a reduction of normal compensation by twenty-five percent (25%) if an employee is injured as a result their willful refusal to use a safety appliance or to observe a

## **MONROE COUNTY EMPLOYEES SAFETY RESPONSIBILITIES AND PROCEDURES**

lawful safety rule. The "Lawful Safety Rule" includes the requirements outlined in this policy, and all safety documents referenced in this policy. Monroe County Drug-Free work place policy provides that compensation will not be paid for injuries sustained while under the influence of drugs or alcohol.

15. Employees working at hazardous tasks will:
  - a. Obey all safety rules and follow published work instructions. If any doubt exists about the safety of doing a task he will "STOP" and get instructions from the Supervisor before continuing work.
  - b. Operate only correct equipment for the task and handle it properly.
  - c. Wear required protective equipment when working in a hazardous operations area. Dress safely and sensibly.

### **CRASH REPORTING PROCEDURES**

1. Employee, if injured
  - a. Report injury to immediate Supervisor as soon as possible.
  - b. Obtain treatment at nearest Emergency Room if injury is severe.
  - c. If the Emergency Room physician prescribes follow-up treatment, approval must be obtained from the Managed Care Provider. The Managed Care Provider must authorize all initial medical treatment after normal working hours prior to any treatment.
  - d. Report in person, or by phone, to the Workers Comp Section when returning to work after a lost time injury.
  - e. Follow instructions from the Workers Comp Section regarding medical release to return to work.
2. Employee: if involved in a County furnished motor vehicle crash;
  - a. Stop immediately.
  - b. Obtain medical aid for injured persons.
  - c. Notify Law Enforcement and contact your Supervisor immediately and advise them of the crash.

NOTE: MINOR VEHICLE CRASHES (without injuries) THAT OCCUR ON COUNTY PROPERTY DOES NOT NEED A LAW ENFORCEMENT REPORT. They must be reported to Risk Management.

- d. Obtain names, addresses, and vehicle tag numbers from other drivers and witnesses.
- e. Prepare the Crash Investigation Report at the scene (refer closely to instructions).

NOTE: All necessary forms and instructions are contained in the glove compartment, or attached to the steering column of all County furnished vehicles.

- f. If the vehicle is no longer operable, the Supervisor should be made aware of this fact and take appropriate action.
  - g. Submit completed Crash Investigation Report form to your immediate Supervisor and coordinate with him/her to assure accuracy of the form.
  - h. Refer Crash Report form to the Risk Manager. If injuries are involved, Supervisor/Department Director will call the Risk Manager.
3. Employee, if involved in a property damage crash,
    - a. Secure the scene of the damage to prevent further damage or personal injuries.
    - b. Notify your immediate Supervisor.

## **MONROE COUNTY EMPLOYEES SAFETY RESPONSIBILITIES AND PROCEDURES**

### **EMPLOYEE SAFETY MEETINGS**

Are required for all employees either twice a year or monthly for those employees working in high hazard areas. They will be documented in the Division Safety Management book. Meetings should be 10 to 30 minutes' duration, consisting of, at a minimum:

1. Past accident summary with preventative measures.
2. Safety training video or training from the required Safety Training List.
3. Review of newly identified hazards.
4. A timely off-the-job safety topic.
5. A discussion period.

The Supervisor will monitor meetings though any member of a department may head the meeting or crew; it is the supervisor's responsibility to ensure the meetings' success. The Safety Representative will monitor the scheduling of employee Safety meetings and ensure all unit employees are scheduled.

### **COUNTY DRIVER PERMITS**

**Purpose** To register, authorize, and control all personnel required to drive County or personal vehicles in the performance of their duties.

#### **Qualifications for Issuance of Driver Permit**

1. All personnel must hold a valid Florida Operators or Commercial Driver's license.
2. All personnel must be sixteen (16) years of age or over.
3. An Operator's permit will be issued only to those who are required to operate a County vehicle in the performance of their normal duties or to certain part-time operators who are required on occasion to drive a County-owned vehicle, or who drive their own personal vehicles on County business.
4. An operator's permit will be authorized by the Safety Office after determination that the person meets the requirements of this manual and has in their possession a valid Florida Driver's license.
5. All employees authorized to operate County vehicles must have in their possession a County Vehicle Operator's Permit during operation of a County vehicle. (On County ID Card)
6. Personnel operating County vehicles will authorize the County to obtain any State, County and/or local public driving records pertaining to them.
7. An employee's right to operate a vehicle on County business shall be denied or revoked at any time when they do not possess a valid State of Florida Operator's or Commercial Driver's License, and may be denied or revoked when their driver's record reflects one or more of the following conditions:

**Class A Violation:** An individual who has a Class A violation within the past three (3) years normally receives a license suspension from the Department of Motor Vehicles. Monroe County calls for a suspension of driving privileges for anyone convicted of a Class A violation for a period of (12) months. Additionally, any of these individuals would also be required to attend an approved driver-improvement program.

- a. Driving while intoxicated or related offense
- b. Driving under the influence of drugs
- c. Negligent homicide arising out of the use of a motor vehicle (gross negligence)
- d. Operation during a period of suspension or revocation
- e. Using a motor vehicle for the commission of a felony

## MONROE COUNTY EMPLOYEES SAFETY RESPONSIBILITIES AND PROCEDURES

- f. Aggravated assault with a motor vehicle
- g. Operation a motor vehicle without owner's permission
- h. Permitting an unlicensed person to drive
- i. Hit and run

**Class B Violation:** An individual who has a combination of two (2) class B moving violation convictions and/or chargeable crash in a three (3) year period will be issued a warning letter from the Safety Office. Any individual who has more than (3) moving violation convictions or three (3) chargeable crash or any combination of more than three (3) of the formerly stated convictions in a (3) year period will be issued a suspension of driving privileges for a period of one (1) year. In addition the individual will be required to complete an approved driver improvement program. All moving violations not listed as Type A violations with unusual circumstances would be evaluated on a one-to-one basis.

- 8. A County Vehicle Operator's Permit may be denied or revoked based on traffic violations demonstrating willful and wanton disregard of traffic rules. Completion of the Defensive Driving course may be a prerequisite to the issuance of an Operator's Permit for a marginal driving record.
- 9. All personnel must report to their supervisor any motor vehicle citations received while operating County or personal vehicles (other than parking violations), or suspension of their license within forty-eight (48) hours. Supervisors are required to discuss the violation with the Safety Administrator to determine the need of revocation of authorization to operate a County vehicle.
- 10. Any denial or revocation of County driving privileges may result in termination of employment.
- 11. Before authorization is granted to operate County vehicles, employees must complete and sign a "County Authorization Employee Driver's Affidavit".
- 12. To receive reimbursement for use of a personal vehicle, employees must complete and sign a "Request and Approval for Car Allowance".
- 13. Any County vehicle transporting an infant, toddler, or child must provide appropriate seating to comply with Florida Department of Motor Vehicle regulations for transporting children.

**MONROE COUNTY SAFETY/ACCIDENT REVIEW BOARD** Mission is to review rules and work methods that will allow safety procedures to be carried out in a productive and cost effective manner and review accident investigation reports to recommend corrective measures to remove hazards from the work-site. We will resolve safety issues, providing employees the opportunity to air concerns regarding any safety matter, involving top management to ensure cooperation and compliance with all applicable safety laws. We will protect the Workers Compensation and Risk Management funds by preventing fraud and promoting a safe and healthy environment.

**Purpose** To assist in the implementation of the Monroe County Board of County Commissioners' policy of insuring the safest possible workplace for its employees and to provide a safe environment for the public that it serves. (See Monroe County Administration Instruction 4704)

### GENERAL SAFETY RULES

It is the responsibility of every employee to know and adhere to the Safety Rules and Regulations, which apply to the area in which he or she is working or visiting.

- 1. **Report all injuries** and property damage to your Supervisor.
- 2. **Report all Unsafe Conditions** to your Supervisor.

## MONROE COUNTY EMPLOYEES SAFETY RESPONSIBILITIES AND PROCEDURES

3. **Fighting**, disorderly conduct, horseplay and practical jokes are prohibited.
4. **Reporting for Work Under the Influence of Intoxicants** will not be permitted. Use of intoxicants during working hours is prohibited. Monroe County is a drug free workplace.
5. **Unauthorized Firearms** or explosives will not be allowed on County property.
6. **Smoking Regulations** shall be observed and obeyed. County policy prohibits smoking in County buildings and County vehicles.
7. **Fatigue can be unsafe:** No person will be permitted to work if their ability or alertness is impaired through fatigue or other causes as to make it unsafe for themselves or their fellow workers.
8. **Employees Shall Not Wear:** jewelry, loose clothing, neckties, loose headbands or have long loose hair when working around or operating rotating machinery and equipment.
9. **Review the Safety Material** posted on bulletin boards or distributed in your work area.
10. **Do Not Operate Machinery While Taking Medication** which warns against the operation of machinery. Report all use of such medication to your Supervisor immediately.

### PROTECTIVE EQUIPMENT AND DEVICES

1. **Guards** installed on machinery and equipment, barriers, and other protective devices provided for employees protection shall not be removed, and will be used in accordance with established rules and procedures.
2. **Personal Protective Equipment** shall be worn when performing work requiring such protection.
3. **All Fire Safety Equipment** such as fire extinguishers, hose racks, hose reels, detectors, fire alarms, and fire lanes shall be kept clear of obstructions and tamper free.
4. **Notify a Supervisor** of fire safety equipment that is damaged or will not operate.
5. **Only Authorized Persons** will enter roped off or barricaded areas.
6. **Emergency Equipment** will not be removed or used except for simulated or actual emergencies.
7. **Report All Instances** where guards are not installed, are inoperative, or are in need of replacement or repair.

### OPERATIONAL HAZARDS

1. **Good Housekeeping** shall be maintained in all areas. Walkways, aisles and working areas shall be kept clean and free of obstructions.
2. **Compressed Air** and other gases under pressure must be used only for the purpose intended.
3. **Do not operate machinery** or equipment unless you are trained and authorized to do so.
4. **Use the right tool for the job:** it is improper to use pliers to drive nails.
5. **Inspect Tools Regularly** for damage and defects. Replace or turn in all defective tools.
6. **Portable Electrical Tool** should be in good condition:
  - a. Portable electrical tools are required to be grounded at the case or frame or grounded by use of a three-wire conductor and plug, if not double insulated. If an extension cord is to be used with the tool, the cord must be of the three-wire grounded type.
  - b. Double-insulated portable electrical tools are internally grounded by incorporating insulation in the case or frame. The wire containing the male plug will have two prongs in the place of three. Check the plate on the tool to ensure that it states that the tool is "double-insulated" and will not require the prescribed ground wire and plug.
  - c. Never use or try to repair unfamiliar power equipment.
  - d. Always protect electric cords from damage by oil, ensure their insulation is not frayed or broken, and keep them clear of aisles where they may be run over by trucks or other equipment or cause a tripping hazard.



**BOARD OF COUNTY COMMISSIONERS**

Mayor Dixie M. Spehar, District 1  
Mayor Pro Tem Charles "Sonny" McCoy, District 3  
George Neugent, District 2  
David P. Rice, District 4  
Murray E. Nelson, District 5

Monroe County Human Resources  
1100 Simonton Street #268  
Key West, FL 33040

OFFICE of the COUNTY ADMINISTRATOR  
Key West, Florida

MONROE COUNTY ADMINISTRATION INSTRUCTION 4703.6

Date: November 8, 2005  
Subject: Drug-Free Workplace Policy  
Reference: (A) Drug-Free Workplace Act - 1988  
Enclosure: (1) Drug Free Workplace Summary  
(2) Employee Acknowledgement  
Effective Date: Upon Receipt

(1) Background:

Reference (A) requires most federal government contractors, as well as recipients of federal grants, to take specific steps to ensure a drug-free workplace for all employees. Provision requires employers to prepare and distribute an anti-drug policy.

(2) Purpose:

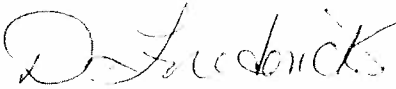
The purpose of this instruction is to establish a program designed to create and maintain a drug-free workplace for Monroe County employees.

(3) Cancellation:

This instruction is to remain in effect until specifically revised or canceled.

(4) Instruction/Action:

A. Enclosure (1) is signed by all new hires and made part of their personnel file.

  
Thomas W. Willi  
County Administrator

Distribution: List III  
Originator: DHR  
Review: 10/7/08

Enclosure (1)

MCA Inst 4703.6

November 8, 2005

## SUMMARY OF DRUG-FREE WORKPLACE POLICY

**EMPLOYEES OF MONROE COUNTY ARE HEREBY NOTIFIED THAT IT IS A CONDITION OF EMPLOYMENT FOR EACH EMPLOYEE TO REFRAIN FROM REPORTING TO WORK OR WORKING WITH THE PRESENCE OF DRUGS OR ALCOHOL IN HIS OR HER BODY. IF AN INJURED EMPLOYEE REFUSES TO SUBMIT TO A TEST FOR DRUGS OR ALCOHOL, PURSUANT TO STATE LAW THE EMPLOYEE MAY FORFEIT ELIGIBILITY FOR MEDICAL AND INDEMNITY BENEFITS.**

### I. WHAT IS THE DRUG-FREE WORKPLACE POLICY?

- A. In accordance with Florida's Drug Free Workplace law, Section 440.101 et seq. (1993), Monroe County ("the County") prohibits the illegal use, possession, sale, manufacture, or distribution, of drugs, alcohol, or other controlled substances on its property. For purposes of this policy alcohol is considered to be a drug.
- B. It is also against County policy for employees to report to work or to work under the influence of drugs or alcohol. This includes prescription drugs which induce an unsafe mental or physical state. Any employee who is taking any prescription drug which might impair safety, performance, or any motor functions should advise his or her supervisor before commencing work under such medication.
- C. For the purpose of this policy, an individual is presumed to be under the influence of drugs or alcohol if a confirmed drug or alcohol test is positive.
- D. The use, sale, purchase, possession, distribution, or dispensing of drugs or alcohol on duty or on County property is cause for immediate discharge.
- E. The County may suspend employees without pay under this policy pending the results of a drug test or investigation.
- F. This County has contracted with a Medical Review Officer (MRO) who is a licensed physician with knowledge of substance abuse disorders, laboratory

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testing procedures, chain of custody collection procedures, the medical use of prescription drugs and the pharmacology and toxicology of illicit drugs. The purpose of the MRO is to ensure to the maximum extent possible that all test results are accurate. Applicants or employees can discuss any technical questions regarding testing with the MRO prior to or after the test.

## II. WHO IS TESTED BY THE COUNTY?

The County tests all employees as described below:

### A. Employees:

1. Reasonable-suspicion Testing: Employees will be tested when there is a reasonable suspicion that an employee is using or has used drugs or alcohol.
2. Post On-the-Job Accident or Injury Testing: Employees who sustain an on-the-job injury, or who have caused, contributed to or have been involved in an accident while at work will be tested at the time medical treatment is administered, or as soon as possible.
3. Routine Fitness-for-Duty Testing: Employees will be drug tested as part of any routinely scheduled employee fitness-for-duty medical examination.
4. Additional Testing: Additional testing may also be conducted as required by applicable state or federal laws, rules, or regulations or as deemed necessary by the County.

## III. WHAT IF AN EMPLOYEE REFUSES TO BE TESTED?

- A. Any employee who refuses to submit to a drug test will be terminated from employment. An injured employee who refuses to submit to a drug or alcohol test, or has a positive confirmation test, in addition to the above, forfeits his or her eligibility for all workers' compensation medical and indemnity benefits.



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IV. WHAT IF SOMEONE TESTS POSITIVE?

- A. Tests will be conducted only by laboratories licensed and approved by the proper state and/or federal agencies. Test specimens will be collected, tested, and stored pursuant to the requirements of Florida law. No physician-patient relationship is created between an employee and the County or any person performing or evaluating a drug test.
- B. Laboratories can now report if a specimen has been tampered with. They can identify the substance used to alter the specimen and can report such substance, in addition to reporting a positive or negative result. An adulterated or tampered with specimen is considered a refusal to test.
- C. The County's Medical Review Officer (MRO) will initially receive and verify that test results were properly analyzed and handled by the laboratory testing. The MRO will then contact the employee to give the person an opportunity to explain or challenge a positive test result to determine whether prescription or other legitimately taken drugs could have caused the positive test result. If the MRO decides that the applicant or employee's explanation is unsatisfactory, the MRO will report a positive test to the County. The County will notify the employee of confirmed positive test results within five (5) working days after receipt of the result from the MRO.
- D. A employee who receives a positive confirmed drug test result may contest or explain the result to the MRO or the County within five (5) days after written notification of the positive test result. If the explanation or challenge is unsatisfactory, a written explanation will be given to the applicant or employee. If the applicant's or employee's challenge is unsatisfactory to the MRO or the County, the applicant or employee has the right to contest the test results pursuant to rules adopted by the Florida Division of Workers' Compensation.
- E. The testing laboratory will preserve specimens of confirmed positive test results for at least 210 days after the result was mailed to the MRO. A employee has the responsibility of notifying the drug testing laboratory of any administrative or civil action brought pursuant to Chapter 440, Florida Statutes. If timely notified, the testing laboratory will maintain the sample until the case or administrative appeal is settled.
- F. Any applicant or employee who elects to have a portion of his or her specimen retested at another licensed testing laboratory (at his or her expense) must notify the testing laboratory and make a request to the County within 180 days after written notification of a positive test result.

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- G. A list of names, addresses, and telephone numbers of employee assistance programs and local drug rehabilitation programs are on file with the County. This information will be provided to any person upon request.

V. WHAT IF AN EMPLOYEE HAS QUESTIONS ABOUT LEGITIMATE PRESCRIPTION DRUG OR OTHER TECHNICAL INFORMATION ABOUT THE TESTS?

- A. Employees have the right to confidentially consult the Medical Review Officer (MRO) for technical information regarding prescription and non-prescription medication and may contest or explain the test result to the MRO both before and after being tested.
- B. Prior to testing, the employee will be given a list of the most common medications by brand name or common name and chemical name which may alter or affect a drug test. This information is on the Drug Testing/Chain-of-Custody/HRS Form 1806.
- C. A Drug Use Information form, which is a confidential report, may be filled out by employees before or after being drug tested. This form permits individuals to provide to the MRO a list of all prescription and non-prescription drugs they are currently using or have used in the last month, as well as any other information they consider relevant to the test.
- D. All information, interviews, reports, statements, memoranda and drug test results, written or otherwise, received by the County as part of this drug testing program are confidential communications. Unless authorized by state laws, rules or regulations, the County will not release such information without a written consent form signed voluntarily by the person tested. The County or its legal counsel may disclose such information in the event that a challenge or other form of civil, disciplinary or administrative litigation is commenced by a employee.

VI. WHAT TYPE OF DRUGS ARE TESTED?

The following is a list of all drugs (described by brand name, common name and/or chemical name) for which the County may test. Also listed and identified are those most common medications which may alter or affect a drug test:

Alcohol (booze, drink, distilled spirits, wine, malt beverages, beer, intoxicating liquors, alcoholic beverages, etc.)

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Amphetamines (Binhetamine, Desoxyn, Dexedrine)

Cannabinoids (marijuana, hashish, hash, hash oil, pot, joint, roach, spleaf, grass, weed, reefer)

Cocaine (coke, blow, nose candy, snow, flake, crack)

Phencyclidine (PCP, angel dust, hog)

Methaqualone

Opiates (opium, dover's powder, paregoric, parepectolin)

Barbiturates (Phenobarbital Tuinal, Amytal)

Benzodiazophines (Ativan, Azene, Klonopin, Dalmane, Diazepam, Halcion, Librium, Poxipam, Restoril, Serax, Tranxene, Valium, Vertron, Xanax)

Methadone (Dolophine, Methadose)

Propoxyphene (Darvocet, Darvon N, Dolene)

Metabolites of any substances listed above.

VII. WHAT ELSE SHOULD I KNOW ABOUT THE POLICY?

- A. Details of this policy may be obtained from the Human Resources Department.
- B. **The contents of this policy constitute statements of the County's current policy and may be changed and updated by the County at any time. Nothing in this policy is intended to create a contract between the County and any employee. Nothing in these guidelines binds the County to a specific or definite period of employment or to any specific policies, procedures, actions, rules, or terms and conditions of employment.**
- C. **As a condition of employment and continued employment, all employees are required to abide by this policy.**

Enclosure (2)

MCA Inst 4703.6

November 8, 2005

**EMPLOYEE ACKNOWLEDGMENT OF RECEIPT  
OF SUMMARY OF DRUG-FREE WORKPLACE POLICY**

I, \_\_\_\_\_, hereby acknowledge that I received a  
(Employee's Name)  
copy of the Monroe County Summary of Drug-Free Workplace Policy, consisting of this page  
and the five (5) preceding typewritten pages on the date indicated below. I understand that on  
the effective date of the policy, it will be a condition of my employment to refrain from reporting  
to work or working with the presence of drugs or alcohol in my body.

\_\_\_\_\_  
(Employee's Signature)

DATE: \_\_\_\_\_



**David A. Knierim, CFP®**  
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South Florida District

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and SEC registered investment adviser.



**Jeffrey Francis**

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Registered Representative of Nationwide Investment Services Corporation, Member NASD  
5900 Parkwood Place, Dublin, OH 43016, 877-677-3678.

In order for the Savings Bond deduction to operate in a timely and efficient manner the following guidelines have been implemented, please read and comply with these guidelines. Your cooperation is appreciated.

#### BASIC GUIDELINES FOR SAVINGS BONDS

The authorization to purchase form **MUST** be completely filled out. If it is not complete it will be returned.

There will be no partial deductions towards obtaining a savings bond. The full amount will be deducted and a bond will be ordered.

There will be no alternating from one pay period to the next of beneficiaries and/or recipients.

The amount necessary to purchase a bond will be deducted each pay period, until written notification is received, requesting the deduction to be stopped. The specific bond request you wish to cancel must be clearly identified.

A Bond request can't be stopped and then "restarted". Once a bond request has been canceled, a new request form must be completed and sent.

SAVINGS BONDS WEBSITE - [WWW.SAVINGSBONDS.GOV](http://WWW.SAVINGSBONDS.GOV)  
1-800-4US BOND

**AUTHORIZATION FOR PURCHASE  
UNITED STATES SAVINGS BONDS**

TYPE OR PRINT IN INK

DATE:

SOCIAL SECURITY #:

EMPLOYEE'S NAME

(First name)

(Initial)

(Last Name)

DEPARTMENT

WORK PHONE

BOND DENOMINATION (cost price)

\_\_\_\_ \$100  
\_\_\_\_ (\$50)

\_\_\_\_ \$200  
\_\_\_\_ (\$100)

\_\_\_\_ \$500  
\_\_\_\_ (\$250)

\_\_\_\_ \$1,000  
\_\_\_\_ (\$500)

BOND OWNER'S NAME

(First Name)

(Middle Name or Initial)

(Last Name)

Bond Owner's Social Security Number This is Required. Do Not submit this form without this number.

Bond Owner's Address  
Number and Street

City, State & Zip

Mail To: Complete this section only if bond is to be mailed to an address that is different than bond owner address.

Name

Number and Street

City, State & Zip

Check One

Co-Owner \_\_\_\_\_

(First Name)

(Middle name or Initial)

(Last Name)

**OR**

Beneficiary \_\_\_\_\_

I hereby authorize the foregoing allotment from my pay for the purchase of U.S. Savings Bonds Series EE to be issued with the inscription shown on this form.

**This authorization is to remain in effect until canceled by me in writing or termination of my employment. (Completing multiple requests will not cancel any other existing requests —each individual request must be canceled in writing.)**

Date

Employee's Signature (Must be same as shown on payroll)



**SERIES I**

**AUTHORIZATION FOR PURCHASE  
UNITED STATES SAVINGS BONDS  
TYPE OR PRINT IN INK**

DATE:

SOCIAL SECURITY #:

\_\_\_\_\_  
EMPLOYEE'S NAME (First name) (Initial) (Last Name)

\_\_\_\_\_  
DEPARTMENT WORK PHONE

\_\_\_\_\_  
BOND DENOMINATION (cost price)

\_\_\_\_ \$50    \_\_\_\_ \$75    \_\_\_\_ \$100    \_\_\_\_ \$200    \_\_\_\_ \$500    \_\_\_\_ \$1,000  
(\$50)    (\$75)    (\$100)    (\$200)    (\$500)    (\$1000)

\_\_\_\_\_  
BOND OWNER'S NAME  
(First Name) (Middle Name or Initial) (Last Name)

\_\_\_\_\_  
Bond Owner's Social Security Number This is Required. Do Not submit this form without this number.

\_\_\_\_\_  
Bond Owner's Address  
Number and Street City, State & Zip

\_\_\_\_\_  
Mail To: Complete this section only if bond is to be mailed to an address that is different than bond owner address.  
Name Number and Street City, State & Zip

\_\_\_\_\_  
Check One  
Co-Owner \_\_\_\_\_ (First Name) (Middle name or Initial) (Last Name)

**OR**

Beneficiary \_\_\_\_\_

I hereby authorize the foregoing allotment from my pay for the purchase of U.S. Savings Bonds Series I to be issued with the inscription shown on this form.

**This authorization is to remain in effect until canceled by me in writing or termination of my employment. (Completing multiple requests will not cancel any other existing requests —each individual request must be canceled in writing.)**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employee's Signature (Must be same as shown on payroll)